UPDATED INFORMATION

Medi-Cal Bulletin **May 16, 2006**

Pharmacy

California Department of Health Services
Emergency Drug Benefit for the Dual Eligible

In order to ensure that people who are dually eligible for Medicare and Medi-Cal continue to get needed medications, the California Legislature has enacted and Governor Arnold Schwarzenegger has signed Assembly Bill (AB) 813 that establishes an Emergency Drug Benefit (EDB) for individuals dually eligible for Medicare and Medi-Cal. AB 813 allows the California Department of Health Services (CDHS), for dates of service from May 17, 2006 through January 31, 2007, to continue covering the cost of medications for dual eligibles that are unable to obtain their medications from the Medicare Part D program.

The EDB established by AB 813 is significantly different than previous programs. AB 813 requires that the CDHS must implement prepayment utilization controls such as a prior authorization process and may establish post-payment audits to review claims paid under the EDB. This process is available in cases where the pharmacy has attempted to obtain coverage under the Medicare Part D program and has failed due to the circumstances noted in AB 813.

For dates of service beginning May 17, 2006, claims may no longer be submitted under this program using a Code 1 restriction indicator. Instead, to use this program, a pharmacy must submit a paper treatment authorization request (TAR) to the Medi-Cal pharmacy field office explaining the reasons the pharmacy could not be paid by Medicare and receive authorization from the State to bill the EDB [see *EDB Prior Authorization Process* below]. This bulletin provides the guidelines and processes the pharmacy provider must follow to submit a prior authorization request and claim to the EDB for payment.

Pharmacies who encounter problems with a Medicare drug plan should contact the Centers for Medicare and Medicaid Services (CMS) Region IX for assistance in problem resolution via the following telephone numbers:

Medicare Advantage Prescription Drug (MA-PD) plans – (415) 744-3617

Prescription Drug Plan (PDP) plans – (415) 744-3628

This contact is not necessary in order to use the State program but is a means to ensure resolution of ongoing problems with the Medicare Part D program.

**** IMPORTANT ****

Pharmacy interactions with the PDP/MA-PD, Medicare, a physician or other party can be by phone, fax or other modes of electronic communication. To receive authorization to use the EDB, a pharmacy must submit a TAR, attach the "California Emergency Drug Benefit for the Dual Eligible TAR Attachment", and check the actions taken under A, B, C, or D, on the form, as appropriate. The pharmacy must document any conversations and retain such documentation and documentation of any other forms of communication for future CDHS auditing purposes. Documentation should include persons' and/or organizations' names, dates, times and contact information for all cases.

The sections below include information on the following areas:

- Circumstances covered by the EDB
- Circumstances not covered by the EDB
- EDB Prior Authorization Process
- Claim Submission Instructions

Circumstances Covered by the EDB

The following is a list of circumstances covered by the EDB. Providers must perform the actions listed and provide attestations[1] when submitting a Treatment Authorization Request (TAR) [see *EDB Prior Authorization Process*]. If the information is not supplied on or with the TAR, the TAR will be denied or deferred.

1. Medicare System Problems or Errors

   "The pharmacy has submitted a claim for the provision of drug benefits to the full-benefit dual eligible beneficiary's Medicare Drug Plan and the claim has been denied payment due to error by the Medicare Program and the pharmacy has made a good faith effort to resolve the error with the Medicare Drug Plan and the Medicare Program."

   The following steps should resolve the system problems or errors encountered by the pharmacy:

   - Contact the PDP/MA-PD to determine why the claim was denied.
   - Take the appropriate steps (e.g. prior authorization or an exception request) required and as directed by the PDP/MA-PD to appropriately bill and receive payment for the drug.

   If the pharmacy is unable to reach resolution of the issue after complying with the requirements/directions provided by the PDP/MA-PD and has made a good faith effort to resolve the error, the pharmacy provider may submit a TAR to the CDHS by following the *EDB Prior Authorization Process* outlined below. *Note: The existence of a denial in and of itself does not constitute a legitimate reason to bill the EDB.*

   If the error is attributable to Medicare and not the PDP/MA-PD, pharmacies are requested to contact CMS at the numbers listed above to request resolution of the ongoing problem.

2. Eligibility / Enrollment Problems

   "The pharmacy is unable to submit a claim for the provision of drug benefits solely due to incomplete or inaccurate Medicare Drug Plan enrollment information from the full-benefit dual eligible beneficiary's Medicare Drug Plan, the federal Centers for Medicare and Medicaid Services, or entities under contract with the Centers for Medicare and Medicaid Services to provide enrollment information, and the pharmacy has attempted to resolve these problems with the Medicare facilitated enrollment contractor and the Medicare Drug Plan, where appropriate."

   A Medicare beneficiary may not have adequate proof of enrollment when presenting a prescription to the pharmacy. If a beneficiary presents without adequate proof of enrollment (e.g. a plan coverage card or letter showing PDP/MA-PD enrollment information) the pharmacy provider can resolve the problem by clarifying the enrollment status of a beneficiary or by enrolling a beneficiary using the tools provided by CMS. The steps and tools available to resolve this issue are:

   - An Eligibility or E1 online transaction should identify the beneficiary's PDP/MA-PD.

[1] Pharmacy interactions with the Medicare Part D drug plan, Medicare, a physician or other party can be by phone, fax or other modes of electronic communication. The pharmacy must document any conversations and retain it and any other forms of communication for future auditing purposes. Documentation requirements are noted herein.

- A telephone inquiry to 1-800-Medicare or the CMS dedicated pharmacy eligibility line at 1-866-835-7595 may also be used to identify the beneficiary's PDP/MA-PD.
- The PDP/MA-PD identified through the above inquires is to be contacted for the beneficiary specific information needed to bill the PDP/MA-PD.
- If the eligibility transaction does not show enrollment in a Medicare drug plan and/or the pharmacy cannot get the information from Medicare, the beneficiary can be enrolled through the Part D Facilitated Enrollment Program. Details on the Facilitated Enrollment Program can be found on the Medi-Cal Web site: www.medi-cal.ca.gov.

After the pharmacy has attempted to identify the plan and the plan's beneficiary specific information or enroll the beneficiary using the Part D Facilitated Enrollment Program as noted but is unable to due to the failure of the systems above, the pharmacy may submit a TAR to the CDHS by following the *EDB Prior Authorization Process* outlined below.

3. Co-payment Problems

"The Medicare Drug Plan provides information that the full-benefit dual eligible beneficiary's deductible or co-payment amount is higher than the co-payment amounts that are established by Medicare for full-benefit dual eligible beneficiaries."

In some instances, a PDP/MA-PD may not have information that the beneficiary is a dual eligible. In these instances a co-payment greater than $5 may be indicated by the PDP/MA-PD. In other cases, Medicare may have the incorrect co-payment amount for a person in a nursing facility. The following steps should resolve the co-payment problems encountered by the pharmacy:

- Verify that the PDP/MA-PD is one of the ten basic plans in which dual eligibles were auto-enrolled. *Phone numbers for each of the plans' pharmacy technical assistance centers is provided on page 6 of this document.* (Note: If the beneficiary has chosen an enhanced plan, the beneficiary may be responsible for higher co-payments and/or deductible amounts. In this instance, inform the beneficiary of this and direct them to 1-800-Medicare to remedy the problem.)
- If the beneficiary is in one of the ten basic plans, contact the PDP and attempt to have the co-payment amount adjusted.
- If the beneficiary is in an MA-PD, contact the MA-DP and attempt to have the co-payment amount adjusted.

It is anticipated that the Centers for Medicare and Medicaid Services (CMS) will be releasing additional guidance to PDP/MA-PD plans regarding co-payments for patients in nursing facilities.

After the pharmacy validates the co-payment amount is in error and has made a good faith effort to resolve the error with the PDP/MA-PD without success, the pharmacy may submit a TAR to the CDHS for approval to bill the EDB for the amount of the co-payment that exceeds what would normally be required from the beneficiary. [see *EDB Prior Authorization Process* and *EDB Claiming Process* below]

4. Prior Authorization/Exceptions Process Problems

"Request for prior authorization or exception to the full-benefit dual eligible beneficiary's Medicare Drug Plan is required and was sought by the pharmacist, but the pharmacy does not receive a response within 24 hours for an emergency drug or within 72 hours for a non-emergency drug. When submitting a request for prior authorization to the department, a pharmacy shall show proof of the submission of the request that was made to either the Medicare Drug Plan or the beneficiary's prescribing physician."

A beneficiary's PDP/MA-PD may require prior authorization (formulary drug) or an exception request (non-formulary drug) for a specific drug. In most situations, the PDP/MA-PD requires the beneficiary's physician to submit the request. To provide for prompt adjudication of a prior authorization or exception request by the PDP/MA-PD, the pharmacy can assist by:

- Immediately notifying the physician of the need for a prior authorization or an exception request. This contact may be done by phone or fax.
- Providing as much information as available to the pharmacy to assist the physician in seeking prior authorization (see item 5 *Prior Authorization* below).
- Verifying with the physician whether the drug, in the physician's judgment, is an "emergency" or a "non-emergency" situation to establish which PDP/MA-PD adjudication timeline is applicable.

If after 24 hours (for an emergency drug) or 72 hours (for a non-emergency drug) the *beneficiary's physician or the Medicare plan does not contact the pharmacy* with a decision by the PDP/MA-PD, the pharmacy provider may submit a TAR to the CDHS. The pharmacy must continue to contact the physician or Medicare Drug plan to obtain authorization for future prescriptions.

During this timeframe, pharmacies may dispense a short term (3 day) or routine (30 day) supply of medications at the time that the beneficiary presents at the pharmacy and bill the EDB for these drugs on a retroactive basis if the conditions specified in this bulletin are met.

NOTE: *On September 1, 2006, AB 813 mandates that Medi-Cal change these deadlines to be linked to when the beneficiary's physician contacts the beneficiary's Medicare drug plan and when the Medicare drug plan responds. CDHS will publish additional guidance to providers in August 2006.*

Circumstances not covered by the EDB

There are instances when claims are denied by the PDP, and coverage of the drug is not available through the EDB.

1. Excluded Drugs
   These should continue to be billed to Medi-Cal as they were prior to January 1, 2006. The pharmacy provider must verify that the drug they are trying to bill to the PDP is not excluded from Part D. Drugs excluded from Part D must continue to be billed to Medi-Cal and not the PDP/MA-PD or the EDB. The categories of excluded drugs that Medi-Cal continues to cover are:

   - Anorexia, weight loss or weight gain
   - Symptomatic relief of coughs and colds
   - Non-prescription drugs (Part D, not Medi-Cal, covers insulin and syringes)
   - Barbiturates
   - Benzodiazepines
   - Prescription vitamins and minerals (Select single vitamins and minerals pursuant to prior authorization or utilization restrictions. Combination vitamin and mineral products are not a benefit. Vitamins or minerals used for dietary supplementation are not a benefit.)

   Additional information on excluded drugs can be found on the Medi-Cal Web site: www.medi-cal.ca.gov. Providers should only submit a TAR for an excluded drug if it is not on the Medi-Cal List of Contract Drugs or exceeds Medi-Cal established utilization controls.

2. Pharmacy Provider Errors
   Claims submitted by the pharmacy to the PDP that exceed the PDP's established utilization control guidelines are not considered errors by the PDP or Medicare. For example, if the pharmacy bills greater than a 30-day supply when only a 30-day supply is allowed by the PDP. In these instances the pharmacy must comply with the PDP requirements and processes (such as prior authorization) and shall not bill the EDB.

3. Inadequate Reimbursement
   The lack of adequate payment (e.g. reimbursement lower than pharmacy cost) is not a legitimate reason to bill the EDB. These issues must be worked out between the provider and the PDP.

4. Standard Medicare Co-payment
   The pharmacy must never bill the dual eligible co-payment ($1-$5) to the EDB. This is a standard design of the Medicare drug program and the beneficiary is responsible for this cost sharing. This includes nursing facility patients who may have a $0 co-payment. (See *Co-payment Problems* above)

5. Prior Authorization

   A denial due to prior authorization or non-formulary status, alone, is not a legitimate reason to bill the EDB. The pharmacy should assist the beneficiary's physician and/or the beneficiary to provide the information needed by the plan to process a prior authorization or exception request.

   A sample coverage determination form that many plans will accept, developed by the American Medical Association and the Association of Health Insurance Plans, is posted online at: http://www.cms.hhs.gov/MLNProducts/Downloads/Form_Exceptions_final.pdf.

   Denial by a plan of a prior authorization or exception request is a statement by the plan that medical necessity does not exist and the pharmacy shall not submit the claim to the EDB. In those instances, the pharmacy should work with the physician to find an alternative therapy or more information to establish the medical need.

   Lack of action on a prior authorization or exception is covered under *Prior Authorization/Exceptions Process Problems* above.

6. Drugs Denied for Safety/Misuse Concerns
   Drugs denied due to drug utilization review shall not be billed to the EDB. The CDHS no longer has a complete drug profile on dual eligibles and therefore has to trust the drug utilization review tools employed by the Part D plans. Pharmacy providers must work with the plan and the beneficiary's physician to address these safety/misuse issues.

7. Transitional Coverage from Acute Care
   For newly enrolled beneficiaries or beneficiaries being discharged from acute care, the pharmacy must access the PDP transitional coverage of drugs or other Plan processes to get the drugs covered. The CMS has indicated that the PDP will accept prior authorization requests and coordination from acute hospital discharge planners. Pharmacy providers should work with the discharge planner to ensure a smooth transition occurs. For any problems in this area, contact the Centers for Medicare and Medicaid Services Region IX staff at:

   MA-PD plans – (415) 744-3617

   PDP plans – (415) 744-3628

Contact Info for Prescription Drug Plans with auto-enrolled dual eligibles

Prescription Drug Plan	CMS Contract #	ID	Pharmacy Technical Assistance	Operated by:
AARP MedicareRx Plan	S5820	031	1-888-492-2952	Walgreen Health Initiative
Blue Cross MedicareRx Value	S5596	033	1-800-662-0210	Anthem Prescription Pharmacy Help Desk
Health Net Orange	S5678	002	1-800-693-8951	Argus
Health Net Orange	S5678	008	1-800-693-8951	Argus
Humana PDP Standard	S5884	090	1-800-865-8715	
Medicare Rx Rewards	S5960	032	1-866-841-8953	Wellpoint Pharmacy Management
PacifiCare Saver Plan	S5921	002	1-800-797-9794	Prescription Solutions
Sierra Rx	S5917	008	1-800 443-8197	
United HealthRx	S5820	140	1-888-492-2952	Walgreen Health Initiative
WellCare Signature	S5967	066	1-866-800-6111	

CALIFORNIA EMERGENCY DRUG BENEFIT (EDB)

PRIOR AUTHORIZATION PROCESS

The CDHS has established a prior authorization process to review the need for a medication before a claim is submitted to the EDB for reimbursement. Pharmacy providers must follow these guidelines regarding TAR submission and documentation requirements. The CDHS has developed a **Medicare Part D Drug Emergency Access** form to assist pharmacy providers in documenting the steps taken prior to submission of the TAR. A sample form and instructions for completing it are attached to this bulletin.

- Pharmacy providers must submit a TAR using the *50-1 or 50-2 Treatment Authorization Request* forms with a copy of the Drug Emergency Access form attached.
- TARs must be faxed or mailed to the appropriate Northern or Southern Medi-Cal Pharmacy Field Office.

  NOTE: Electronic TAR submission is not allowed under the EDB
- The pharmacy provider must note on an attached Medicare Part D Drug Emergency Access form the steps taken to resolve the problem.
- For drugs that would normally require prior authorization in the Medi-Cal program (i.e. drugs that are not on, or that exceed the restrictions of, the Medi-Cal List of Contract Drugs), the pharmacy provider must document the medical necessity.
- In addition to the Diagnosis, the pharmacy provider must indicate "Part D Emergency TAR" in the *Diagnosis Description* section of the TAR and enter the code "R48" in the *Service Category* field at the top of TAR. Doing so enables the CDHS to appropriately track and handle these TAR requests.
- *Units of Service* requested must be "1". The CDHS will not approve multiple refills through this process.
- The quantity of medication requested must not be greater than the amount the beneficiary's PDP/MA-PD will allow for a single dispensing. For example, if the PDP only allows for 30 tablets of a specific drug, the TAR request must be for a quantity of 30 or less. If the unresolved problem is due to a prior authorization or exception request related to a quantity override, the pharmacy may enter the quantity being requested from the PDP/MA-PD.

EDB Claiming Process

- Providers are to submit claims in the same way they submit other prescription drug claims to Medi-Cal.
- Because the process now requires a TAR, providers should not indicate that the Code I restriction has been met.
- Providers are reminded to include the TAR number on the claim or the claim will be denied.
- For claims where Medicare has set the co-payment amount to be greater than that for dual-eligible beneficiaries ($1 to $5), the pharmacy must submit an "other coverage" claim. The amount-billed field must contain the pharmacy's usual and customary charge for the prescription and the other-coverage-paid field must contain the amount that the Medicare program is reimbursing the pharmacy plus the normal co-payment due from the patient. This is the same method used for all Medi-Cal claims for beneficiaries who have other coverage.
- Claims will be reimbursed based on the rates established for the Medi-Cal program.

California Emergency Drug Benefit for the Dual Eligible
TAR attachment

Instructions:

1. Enter Beneficiary Name – must match the name on the Treatment Authorization Request (TAR) form (50-1 or 50-2).

2. Enter Beneficiary Medi-Cal Identification number - must match the number on the TAR form.

3. Enter the TAR sequence number from the TAR form.

4. Select only one of the four sections that describe the circumstance requiring emergency drug coverage.

5. Check or fill-in only the actions actually performed by the pharmacy. In "Date/Time" fields, use MM/DD/YYYY for the date and a 24 hour clock, i.e. 0900 **not** 9:00 am, for the time.

6. Send the form as an attachment with the TAR via fax or by mail.

EXAMPLE

The pharmacy provider finds that a drug needs prior authorization approval from the Part D plan. The pharmacist contacts the physician and informs him/her of this fact and provides pertinent information for the physician to use in seeking prior authorization. You ascertain from the physician that the drug does not need to start right away (i.e. it is a non-emergency drug). After 72 hours, the pharmacy provider has not received information that the prior authorization has been approved or denied by the plan.

The pharmacy provider can then submit a TAR. In this instance, because the reason is a prior authorization issue, the pharmacy provider would fill out the following section:

D. Prior Authorization/Exceptions Process Problems

The following steps were taken to obtain prior authorization in a timely manner.

1. Notified prescriber regarding the need for a prior authorization or an exception request. X

   Notification Date: 5/20/2006 Notification Time: 1100

2. Verified with the prescriber the "emergency" / "non-emergency" status of the drug. X

   Check one: Emergency _____ Non-Emergency X

California Emergency Drug Benefit for the Dual Eligible
TAR attachment

Beneficiary Name (Last, First, M.I.)	Medi-Cal Identification Number	TAR CONTROL NUMBER - -

A. Medicare System Errors
The following steps were taken to resolve system errors with the beneficiary's PDP/MAPD or with Medicare:

1. PDP/MAPD contacted to determine why the claim was denied. _____
2. Medicare was contacted to resolve the problem. _____
3. Pharmacy took actions required/directed by the PDP/MA-PD _____

B. Eligibility / Enrollment Problems
The following steps were taken to resolve problems regarding the beneficiary's eligibility/enrollment:

1. An Eligibility or E1 online transaction. _____
2. A telephone inquiry to 1-800-Medicare or the CMS dedicated pharmacy eligibility line at 1-866-835-7595. _____
3. The PDP/MA-PD contacted for the beneficiary billing information. _____
4. Attempted to enroll the beneficiary through the Part D Facilitated Enrollment Program. _____

C. Co-Payment Problems
The following steps were taken to resolve co-payments and/or deductible amounts higher than those established for full-benefit dual eligible beneficiaries.

1. Verified that the PDP/MA-PD is one of the ten basic plans _____
2. Contacted the PDP/MA-PD; requested the co-payment amount adjusted _____

D. Prior Authorization/Exceptions Process Problems
The following steps were taken to obtain prior authorization in a timely manner.

3. Notified prescriber regarding the need for a prior authorization or an exception request. _____

   Notification Date: _____ Notification Time: _____

4. Verified with the prescriber the "emergency" / "non-emergency" status of the drug. _____

Check one: Emergency _____ Non-Emergency _____